NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)

PREAMBLE

1.	**Sections Affected**	**Rulemaking Action**
	R9-22-501	Amend
	R9-22-502	Amend
	R9-22-503	Amend
	R9-22-504	Amend
	R9-22-505	New Section
	R9-22-509	Amend
	R9-22-512	Amend
	R9-22-518	Amend
	R9-22-521	Amend
	R9-22-522	Amend

2. The specific authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):

Authorizing statute: A.R.S. § 36-2903

Implementing statute: A.R.S. §§ 36-2903, 36-2903.01, 36-2907

3. The effective date of the rules:

This rulemaking will be effective 60 days from the date of filing with the Secretary of State.

4. A list of all previous notices appearing in the *Register* addressing the final rules:

Notice of Rulemaking Docket Opening: 14 A.A.R. 2784, July 11, 2008

Notice of Proposed Rulemaking: 14 A.A.R. 2964, August 1, 2008

5. The name and address of agency personnel with whom persons may communicate regarding the rulemaking:

Name: Mariaelena Ugarte

Address: AHCCCS
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Phoenix, AZ 85034

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6. An explanation of the rule, including the agency's reasons for initiating the rule:

The Administration is proposing rule changes as a result of a 5-Year Rule-Review recently conducted. The topics requiring an update are: definitions, provision of member's medical records, completion of audits, and other technical updates.

7. A reference to any study relevant to the rule that the agency reviewed and either relied on in its evaluation of or justification for the rule or did not rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:

No study was reviewed during this rulemaking and the Agency does not anticipate reviewing any studies.

8. A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:

Not applicable

9. The summary of the economic, small business, and consumer impact:

The Administration anticipates that there will be no economic impact as a result of the rule changes. The changes provide clarification of current processes and technical updates, therefore not requiring a change in practices for those affected by the rulemaking.

10. A description of the changes between the proposed rules, including supplemental notices, and final rules (if applicable):

Where R9-22-522 explains that a provider must provide medical records within 30 days, was not stricken and left as written due to the public comment received. No other changes have been made between the proposed rules and the final rules below except that the Administration made the rules more clear, concise, and understandable by making grammatical, verb tense, punctuation, and structural changes throughout the rules.

11. A summary of the comments made regarding the rule and the agency response to them:

The Administration received the following comments:

Numb:	Date/ Commentor:	Comment:	Response:
1.	08/19/08 Kathy Harris Health Choice Arizona	R9-22-522(D) The provision requiring providers, whose contract with a contractor has been terminated, to pass on medical records was stricken. This provision is needed to legally require terminated providers to pass on records.	The Administration agrees and will not strike the provision.
2.	08/30/08	R9-22-522(C)	The Administration does not have the

	Susyn Rasmussen AHCCCS member	Provision where a PCP must also maintain medical records for ER services provided by non-contracting providers was stricken. 1. Member states her PCP was not notified of an ER service, therefore could not maintain an appropriate record, making it difficult for her to get continuing care. 2. Member states that she is denied her primary Medicare benefits since she is on Medicaid. And the Contractor will not pay for her medical services since they were received out of network. Without the technical changes a contractor could not pick and chose what they want to treat.	authority to impose on an out of network provider to provide the PCP with medical records. It is recommended that the member obtain the member's records and provide the records to the member's PCP.
3.	08/30/08 Susyn Rasmussen AHCCCS member	The comment concerned changes made to R9-29-302 effective March 2006. Attachments refer to: Contractor Operations Manual Chapter 200 (A) Covered Services for QMB Duals and Non-QMB Duals. Chapter 201 Medicare Cost Sharing for Members in Medicare FFS Purpose and Definition section. Cost Sharing Matrix, Limits on Cost Sharing, Prior Authorization.	R9-29-302 is not within the scope of this rulemaking. The point made will be considered during any future rulemakings that include R9-29-302.

12. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:

Not applicable

13. Incorporations by reference and their location in the rules:

Not applicable

14. Was this rule previously adopted as an emergency rule?

No

15. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

ARTICLE 5. GENERAL PROVISIONS AND STANDARDS

Section

R9-22-501. General Provisions and Standards - Related Definitions

R9-22-502. Pre-existing Conditions

R9-22-503. Provider Requirements Regarding Records

R9-22-504. Marketing; Prohibition against Inducements; Misrepresentations; Discrimination; Sanctions

R9-22-505. ~~Repealed~~ Standards, Licensure, and Certification for Providers of Hospital and Medical Services

R9-22-509. Transition and Coordination of Member Care

R9-22-512. Release of Safeguarded Information

R9-22-518. Information to Enrolled Members

R9-22-521. Program Compliance Audits

R9-22-522. Quality Management/Utilization Management (QM/UM) Requirements

ARTICLE 5. GENERAL PROVISIONS AND STANDARDS

R9-22-501. General Provisions and Standards - Related Definitions

In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

"Quality management" means a process used by professional health personnel through a formal program involving multiple organizational components and committees to:

Assess the degree to which services provided conform to desired medical standards and practices; and

~~Improve or maintain quality service and care.~~ Quality improvement or maintenance of care and services.

"Quality Improvement" means a process designed to achieve, through ongoing measurements and intervention, significant improvement that is sustained over time, in the areas of clinical care and non-clinical care and is expected to have a favorable effect on health outcomes and member satisfaction. Quality Improvement includes focusing organizational efforts on improving performance and utilizing data to develop intervention strategies to improve performance and outcomes.

"Utilization management/review" means a methodology used by professional health personnel to assess the medical indications, appropriateness, and efficiency of care provided. Utilization management applies to a contractor's process to evaluate and approve or deny the medical necessity, appropriateness, efficacy and efficiency of health care services, procedures, or settings. Utilization review includes processes for prior authorization, concurrent review, retrospective review, and case management.

R9-22-502. Pre-existing Conditions

A. Except as otherwise provided in ~~Article 3~~ Article 2 of this Chapter, a contractor shall be responsible for providing the full scope of covered services to each member from the effective date of eligibility until the termination of enrollment or transfer of the member to another contractor. A contractor shall not impose a pre-existing condition exclusion with respect to covered services.

B. A contractor or subcontractor shall not adopt or use any procedure to identify a person who has an existing or anticipated medical or psychiatric condition in order to discourage or exclude the person from enrolling in the contractor's health plan or encourage the person to enroll in another health plan.

R9-22-503. Provider Requirements Regarding Records

The provider shall maintain records that meet uniform accounting standards and generally accepted practices for maintenance of medical records, including detailed specification of all patient services delivered, the rationale for delivery, and the service date. A provider shall maintain and upon request, make available to a contractor and to the Administration, financial, and medical records relating to payment for not less than five years from the date of final payment, or for records relating to costs and expenses to which the Administration has taken exception, five years after the date of final disposition or resolution of the exception. ~~The provider shall maintain records that meet uniform accounting standards and generally accepted practices for maintenance of medical records, including detailed specification of all patient services delivered, the rationale for delivery, and the service date.~~ Providers shall provide one copy of a medical record at no cost if requested by the member.

R9-22-504. Marketing; Prohibition against Inducements; Misrepresentations; Discrimination; Sanctions

A. A contractor or the contractor's marketing representative shall not offer or give any form of compensation or reward, or engage in any behavior or activity that may be reasonably construed as coercive, to induce or procure AHCCCS enrollment with the contractor. Any marketing solicitation offering a benefit, good, or service in excess of the covered services in Article 2 is deemed an inducement.

B. A marketing representative shall not misrepresent itself, the contracting health plan represented, or the AHCCCS program, through false advertising, false statements, or in any other manner to induce a member of another contractor to enroll in the represented health plan.

~~1.~~ Violations of this subsection include, but are not limited to, false or misleading claims, inferences, or representations such as:

~~a.~~1. A member will lose benefits under the AHCCCS program or lose any other health or welfare benefits to which a member is legally entitled, if the member does not enroll in the represented contracting health plan;

~~b.~~2. Marketing representatives are employees of the state or representatives of the Administration, a county, or any health plan other than the health plan by which they are employed, or by which they are reimbursed; and

~~c.~~3. The represented health plan is recommended or endorsed as superior to its competition by any state or county agency, or any organization, unless the organization has certified its endorsement in writing to the health plan and the Administration.

C. A marketing representative shall not engage in any marketing or pre-enrollment practice that discriminates against a member because of race, creed, age, color, sex, religion, national origin, ancestry, marital status, sexual preference, physical or mental disability, or health status.

D. The Administration shall hold a contractor responsible for a violation of this Section resulting from the performance of any marketing representative, subcontractor, agent, program, or process under the contractor's employ or direction and shall impose contract sanctions on the contractor as specified in contract.

E. A contractor shall produce and distribute informational materials that are approved by the Administration to each enrolled member or designated representative after the contractor receives notification of enrollment from the Administration. The contractor shall ensure that the informational materials include, at a minimum:

1. A description of all covered services as specified in contract;
2. An explanation of service limitations and exclusions;
3. An explanation of the procedure for obtaining services;
4. An explanation of the procedure for obtaining emergency services;
5. An explanation of the procedure for filing a grievance and appeal; and
6. An explanation of when plan changes may occur as specified in contract.

R9-22-505. ~~Repealed~~ Standards, Licensure, and Certification for Providers of Hospital and Medical Services

A provider shall not provide hospital or medical services to a member unless the provider is licensed by the Arizona Department of Health Services and meets the requirements in 42 CFR 441 and 482, as of October 1, 2007, and 42 CFR 456 Subpart C, as of October 1, 2007, incorporated by reference, on file with the Administration and available from the U.S. Government Printing Office, 732 N. Capitol St, NW, Washington, D.C., 20401. This incorporation contains no future editions or amendments. An Indian Health Service (IHS) hospital and a Veterans Administration hospital shall not provide services to a member unless accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

R9-22-509. Transition and Coordination of Member Care

~~**A.** The Administration shall coordinate and implement disenrollment and re-enrollment procedures when a member's change of residency requires a change in contractor.~~

~~B.~~A. A contractor shall assist in the transition of members to and from other AHCCCS contractors.

1. Both the receiving and relinquishing contractor shall:
    a. Coordinate with the other contractor to facilitate and schedule appointments for medically necessary services for the transitioned member within the Administration's timelines specified in the contract. If requested by the Administration, a contractor shall submit the policies and procedures regarding transition of members to the Administration for review and approval;
    b. Assist in the referral of transitioned members to other community health agencies or county medical assistance programs for medically necessary services not covered by the Administration, as appropriate; and
    c. Develop policies and procedures to be followed when transitioning members who have significant medical conditions; are receiving ongoing services; or have, at the time of the transition, received prior authorization or approval for undelivered, specific services.
2. The relinquishing contractor shall notify the receiving contractor of relevant information about the member's medical condition and current treatment regimens within the timelines defined in contract;
3. The relinquishing contractor shall forward medical records and other relevant materials to the receiving contractor. The relinquishing contractor shall bear the cost of reproducing and forwarding medical records and other relevant materials;
4. Within the ~~contract specified~~ timelines specified in contract, the receiving contractor shall ensure that the member selects or is assigned to a primary care provider, and provide the member with:
    a. Information regarding the contractor's providers,
    b. Emergency numbers, and
    c. Instructions about how to obtain services.

~~C.~~**B.** A contractor shall not use a county or noncontracting provider health resource alternative to diminish the contractor's contractual responsibility or accountability for providing the full scope of covered services. The Administration may impose sanctions as described in contract if a contractor makes referrals to other ~~health~~ agencies or programs to reduce expenses incurred by the contractor on behalf of its members.

R9-22-512. Release of Safeguarded Information

A. The Administration, contractors, providers, and noncontracting providers shall limit the release of safeguarded information to persons or agencies for the following purposes in accordance with 45 CFR ~~Part~~ 160 and 45 CFR

~~Part~~ 164, October 1, 2004, and 42 CFR 431.300 through 431.307, October 1, 2004, incorporated by reference, ~~and~~ on file with the Administration and available from the U.S. Government Printing Office, ~~Mail Stop: IDCC,~~ 732 N. Capitol ~~Street~~ St, NW, Washington, ~~DC~~ D.C., 20401. This incorporation by reference contains no future editions or amendments:

1. Official purposes directly related to the administration of the AHCCCS program including:
    a. Establishing eligibility and post-eligibility treatment of income, as applicable;
    b. Determining the amount of medical assistance;
    c. Providing services for members;
    d. Performing evaluations and analysis of AHCCCS operations;
    e. Filing liens on property as applicable;
    f. Filing claims on estates, as applicable; and
    g. Filing, negotiating, and settling medical liens and claims.
2. Law enforcement. The Administration may release safeguarded information without the applicant's or member's written or verbal consent, for the purpose of conducting or assisting an investigation, prosecution, or criminal or civil proceeding related to the administration of the AHCCCS program.
3. The Administration may release safeguarded member information to a review committee in accordance with the provisions of A.R.S. § 36-2917, without the consent of the applicant or member.

B. Except as provided in subsection (A), the Administration, contractors, providers, and noncontracting providers shall disclose safeguarded information only to:

1. An applicant;
2. A member;
3. An unemancipated minor, with written permission of a parent, custodial relative, or designated representative, if:
    a. An Administration employee, authorized representative, or responsible caseworker is present during the examination of the safeguarded information; or
    b. After written notification to the provider, and at a reasonable time and place.
4. Persons authorized by the applicant or member, or

5. A ~~lawful~~ court order or subpoena ~~accompanied by an authorization~~ compliant with 45 CFR ~~164.508~~ 164.512(e) ~~October 1, 2004, or qualified protective court order as defined by 45 CFR 164.512~~, October 1, 2004, incorporated by reference, ~~and~~ on file with the Administration and available from the U.S. Government Printing Office, ~~Mail Stop: IDCC,~~ 732 N. Capitol ~~Street~~ St, NW, Washington, ~~DC~~ D.C., 20401. This incorporation by reference contains no future editions or amendments.

C. The Administration, contractors, providers, and noncontracting providers shall safeguard ~~identifying~~ identifiable information, protected health information as specified in 45 CFR ~~Part~~ 160, and information obtained in the course of application for or redetermination of eligibility concerning an applicant or member, that includes, but is not limited to the following:

1. Name and address;
2. Social Security number;
3. Social and economic conditions or circumstances;
4. Agency evaluation of personal information;
5. Medical data and information concerning medical services received, including diagnosis and history of disease or disability;
6. State Data Exchange (SDX) tapes, and other types of information received from outside sources for the purpose of verifying income eligibility and amount of medical assistance payments; and
7. Any information received in connection with the identification of legally liable third-party resources.

D. The restriction upon disclosure of information in this Section does not apply to:

1. De-identified information as described by 45 CFR ~~Part~~ 164.514, October 1, 2004, incorporated by reference in subsection (A); or
2. A disclosure, in response to a request for information, that complies with 45 CFR ~~Part~~ 160 and 45 CFR ~~Part~~ 164, October 1, 2004, and 42 CFR 431.300 through 431.307, October 1, 2004, incorporated by reference in subsection (A).

E. A provider shall furnish records requested by the Administration or a contractor to the Administration or the contractor at no charge.

R9-22-518. Information to Enrolled Members

A. Each contractor shall produce and distribute printed informational materials to each member or family unit ~~within~~ no later than 10 days of receipt of notification of enrollment from the Administration. The contractor shall ensure that the informational materials meet the requirements specified in the contractor's current contract.

B. A contractor shall provide a member with the name, address, and telephone number of the member's primary care provider ~~within~~ no later than 10 days from the date of enrollment. The contractor shall include information on how the member may change primary care providers.

R9-22-521. Program Compliance Audits

A. The Administration shall conduct an onsite program compliance audit of a contractor at least once every ~~12 months~~ three years during the term of the Administration's contract with the contractor. ~~Unless the Administration determines that advance notice will render the program compliance audit less useful, the Administration shall notify a contractor approximately three weeks in advance of the date of an onsite program compliance audit.~~ The Administration may conduct, without prior notice, inspections of contractor facilities or perform other elements of a program compliance audit.

B. An audit team may perform any or all of the following procedures:

1. Conduct private interviews and group conferences with members, physicians, other health professionals, and members of the contractor's administrative staff including, but not limited to, the contractor's principal management persons;
2. Examine records, books, reports, and papers of the contractor and any management company, and all providers or subcontractors providing health care and other services. The examination may include, but need not be limited to: minutes of medical staff meetings, peer review and quality of care review records, duty rosters of medical personnel, appointment records, written procedures for the internal operation of the health plan, contracts and correspondence with members and with providers of health care services and other services to the plan, and additional documentation deemed necessary by the Administration to review the quality of medical care.

R9-22-522. Quality Management/Utilization Management (QM/UM) Requirements

A. A contractor shall comply with Quality Management/Utilization Management (QM/UM) requirements specified in this Section and in contract. The contractor shall ensure compliance with QM/UM requirements that are accomplished through delegation or subcontract with another party.

B. In addition to any requirements specified in contract, a contractor shall:

1. Submit to the Administration a written QM/UM plan that includes a description of the systems, methodologies, protocols, and procedures to be used in:
    a. Monitoring and evaluating the types of services provided,
    b. Identifying the numbers and costs of services provided,
    c. Assessing and improving the quality and appropriateness of care and services,
    d. Evaluating the outcome of care provided to members, and
    e. Determining the actions necessary to improve service delivery;
2. Submit the QM/UM plan to the Administration on an annual basis within timelines specified in contract. If the QM/UM plan is changed during the year, the contractor shall submit the revised plan to the Administration before implementation;
3. Receive approval from the Administration before implementing the initial or revised QM/UM plan;
4. Ensure that a QM/UM committee operates under the control of the contractor's medical director and includes representation from medical and executive management personnel. The committee shall:
    a. Oversee the development, revision, and implementation of the QM/UM plan; and
    b. Ensure that there are qualified QM/UM personnel and sufficient resources to implement the contractor's QM/UM activities; and
5. Ensure that the QM/UM activities include at least:
    a. Prior authorization for non-emergency or scheduled hospital admissions;
    b. Concurrent review of inpatient hospitalization;
    c. Retrospective review of hospital claims;
    d. Program and provider audits designed to detect over- or under-utilization, service delivery effectiveness, and outcome;
    e. Medical records audits;
    f. Surveys to determine satisfaction of members;
    g. Assessment of the adequacy and qualifications of the contractor's provider network;
    h. Review and analysis of QM/UM data; ~~and~~

~~i. Other activities necessary to improve the quality of care and the efficient, cost effective delivery and utilization of services.~~

i. Measurement of performance using objective quality indicators;

j. Ensuring individual and systemic quality of care;

k. Integrating quality throughout the organization;

l. Process improvement;

m. Credentialing a provider network;

n. Resolving quality of care grievances; and

o. Quality improvement activities focused on improving the quality of care and the efficient, cost-effective delivery and utilization of services.

C. A member's primary care provider shall maintain medical records that:

~~1. Are detailed and comprehensive and identify:~~

~~a. All medically necessary services provided to the member, and~~

~~b. All emergency services provided by a noncontracting provider for a member.~~

~~2.~~1. Conform to professional medical standards and practices for documentation of medical diagnostic and treatment data;

~~3.~~2. Facilitate follow-up treatment; and

~~4.~~3. Permit professional medical review and medical audit processes.

D. ~~A~~ Within 30 days following termination of the contract between a subcontractor and a contractor, the subcontractor or the subcontractor's designee shall forward to the primary care provider medical records or copies of medical records of all members assigned to the subcontractor or for whom the subcontractor has provided services~~,~~. ~~within 30 days following termination of the contract between the subcontractor and the contractor.~~

E. The Administration shall monitor each contractor and the contractor's providers to ensure compliance with Administration QM/UM requirements and adherence to the contractor's QM/UM plan.

1. A contractor and the contractor's providers shall cooperate with the Administration in the performance of the Administration's QM/UM monitoring activities; and

2. A contractor and the contractor's providers shall develop and implement mechanisms for correcting deficiencies identified through the Administration's QM/UM monitoring.